AUTHORIZATION FORM TO USE AND DISCLOSE
YOUR PROTECTED HEALTH INFORMATION

PLEASE READ THIS DOCUMENT CAREFULLY

This is an authorization form that will permit Medical Procedures Center ("Covered Entity") to use or disclose some of your protected health information. Covered Entity will not condition treatment on whether you sign this authorization. You have the right to revoke this authorization at any time by sending a *written* revocation to:

Medical Procedures Center, P.C.
4800 N.Saginaw Road
Midland, MI. 48640

Your revocation will not apply, however, to uses and disclosures Covered Entity has already made in reliance on your authorization.

I authorize Medical Procedures Center, P.C. to use and disclose the following health information about me: [DESCRIBE WHO IS RELEASING INFORMATION AND GIVE ADDRESS]

_____
_____
_____

To the following entity or persons:

[DESCRIBE TO WHOM INFORMATION WILL BE RELEASED AND GIVE ADDRESS]

_____
_____
_____

This authorization is valid until _____, 20___.

Please provide the following information if you are a personal representative of a patient of The Medical Procedures Center, P.C.

Name of patient: _____

Description of personal representative's authority:

Please Read Carefully and Sign

I understand that The Medical Procedures Center will use or disclose my health information as described above until this authorization expires. I understand that I will receive a copy of this signed authorization for my records. I also understand that any health information released pursuant to this authorization might be re-disclosed by the recipient, and that any such re-disclosure may not be protected by law.

_____ _____

By: Patients Signature

Date

Print Name _____

D.O.B _____

Employee's initials_____